CHAPTER 4-000 Nebraska Medical Assistance Program (NMAP: NMAP provides medical care and services to dependent children and responsible relatives living as a family unit, who do not have sufficient income to meet their medical needs, and who qualify according to the program definitions.

4-001 Eligibility Criteria

4-001.01 Eligibility Requirements: To be eligible for ADC/MA only, the individual must meet the following requirements:

1. Face to face interview (see 468 NAC 2-001);
2. U.S. citizenship or alien status (see 468 NAC 2-002);
3. Nebraska residence (see 468 NAC 2-003);
4. Social Security number (see 468 NAC 2-004);
5. Deprivation of parental support or care (see 468 NAC 4-001.01F);
6. Relative responsibility (see 468 NAC 2-006);
7. Age requirements for dependent children (see 468 NAC 4-003);
8. Resources (see 468 NAC 4-006);
9. Income (see 468 NAC 4-007);
10. Cooperation with requirements for third party medical payments (see 468 NAC 4-002);
11. Enrollment in an available health plan (see 468 NAC 4-001.01C); and
12. Cooperation with the Child Support Enforcement Unit (see 468 NAC 4-002.07).

4-001.01A Individuals Eligible for MA Without a Separate Application: The following individuals are automatically eligible for MA without a separate eligibility determination:

1. Clients who receive an assistance grant, including clients who do not receive a payment because of the $10 minimum payment are eligible for MA.
2. ADC/MA clients who become ineligible for an assistance payment because of increased earnings or increased hours of employment are eligible for up to 12 months of MA (see 468 NAC 4-001.01A2).
3. ADC/MA clients who become ineligible wholly or partially because of the collection or increased collection of child/spousal support are eligible for four months of MA if the case received a grant in three of the six months preceding ineligibility.

4. Essential children, as defined by SSI, of AABD recipient(s) who would receive a state supplemental payment, or would receive a payment except the SSI exceeds the AABD budgetary need are eligible for MA.

   For numbers 2, 3, and 4, medical eligibility begins with the month after the last grant payment is issued (or the unit was eligible but did not receive a payment because of the $10 minimum). If the worker determines that the unit was ineligible for a grant, medical eligibility is determined to have begun with the first month in which the ADC grant was erroneously paid.

5. A pregnant woman is eligible for post-partum medical services. The 60-day post-partum period ends at the end of the second month following the month the pregnancy ended. An ineligible mother of an eligible unborn or newborn is still eligible for the 60-day post-partum period.

6. Once an unborn has been determined eligible, the eligibility continues through the month the child turns age one, without regard to changes in the household income, as long as the newborn continues to reside with his/her mother in Nebraska.

7. Until June 30, 2003, ADC/MA families with income equal to or less than 50% of the Federal Poverty Level.

{Effective 10/15/2002}

4-001.01A1 Eligibility of Family Members: The Medicaid eligibility of each family member must be determined based on the family's total countable income. The family's income is compared to the appropriate income standard for a family of that size. The worker must determine the eligibility of:

1. Uninsured children at an income level no greater than 185% of the Federal Poverty Level;
2. Insured children at an income no greater than the appropriate Federal Poverty Level determined by the child's age;
3. Adults using income standards no greater than the applicable medical categorical eligibility standards established by federal or state law.

For examples, see 468-000-303.

4-001.01A2 Eligibility for Transitional Medical Assistance (TMA): ADC/MA clients are eligible for up to 12 months of TMA without a share of cost if all of the following are met:

1. The case has earned income which results in ineligibility for a grant (or in conjunction with other factors results in ineligibility for a grant);
   Note: The parent or needy caretaker relative or guardian or conservator must be in the household.
2. The unit received a grant for which they were eligible (or did not receive a grant but met income and resource eligibility to receive a grant) in three of the last six months preceding ineligibility;
3. The parent or needy caretaker relative or needy guardian or conservator is employed.

The unit is ineligible for TMA if it received a grant in one or more of the three qualifying months as a result of convicted fraud during the last six months before the beginning of the transitional period.

The unit must submit the required reports [see 468 NAC 4-001.01A2c(1)] in order to continue to receive TMA in the second six months. See 468-000-327 for the ADC Transitional Timeline.

There is no resource test while the unit is in TMA.

Note: The TMA unit may be subject to a premium beginning with Month 7. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

A family that was granted TMA eligibility before November 1, 2002, will have their total period of TMA reduced to a maximum of 12 months.

4-001.01A2a Eligible Family Members: If a family member, such as a parent or a child, returns to the home, the worker must consider grant eligibility for the whole family. If the returning family member is a responsible relative, the worker must add in the relative's income and compare the family's income to the income guideline for the unit plus the responsible relative. If the family is ineligible for a grant, the returning family member is added to the TMA unit. A child who is born or adopted while the family is receiving TMA is added to the TMA unit.

A parent who has been sanctioned while on grant for failure to cooperate with Employment First may be included in the TMA unit. A parent who has been sanctioned for noncooperation with child support or TPL is not eligible until cooperation is resolved.

Once a client is in TMA, s/he is not required to cooperate with program requirements such as Employment First, TPL, and child support.

4-001.01A2b Removed Family Members: If a unit member leaves the home, the worker shall consider grant eligibility for the remaining unit members. If the family is ineligible for a grant, the remaining unit members may continue to be eligible for TMA. If it is the only dependent child who leaves, the whole unit loses eligibility for TMA.

If the only child no longer meets the age qualification (see 468 NAC 4-003), the unit loses eligibility for TMA. Before closing the case, the worker shall determine if the child is eligible for another assistance program, such as Ribicoff or SAM.

4-001.01A2c Initial Six Months:

4-001.01A2c(1) Report Requirement: The unit shall report the gross monthly earnings and child care costs as billed or paid for each of the first three months of the transitional period. The first report is due by the 21st day of the fourth month. The second report is due by the 21st of the seventh month.
Note: The unit is not required to report unearned income.

4-001.01A2c(2) Causes of Termination: The unit becomes ineligible for TMA if -

1. The unit becomes eligible for a grant;
2. The unit moves out of the state;
3. There no longer is an eligible dependent child in the unit.
   Note: If the only child is receiving AABD or SSI, the parent(s) may be eligible for TMA.

If the unit regains grant eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant eligibility because of earnings, the original TMA cycle resumes. If the unit receives three or more ADC grants, then again loses grant eligibility because of earnings, a new TMA cycle begins.

If the unit becomes grant eligible again because of loss of income, the client may refuse the grant in order to continue receiving TMA.

{Effective 5/8/05}

4-001.01A2d Months 7 through 12: Beginning with month 7, the household is subject to payment of a monthly premium if their countable income is between 100 and 185 percent of the Federal Poverty Level, see 468-000-215.

{Effective 5/8/05}

4-001.01A2d(1) Causes for Termination: The unit is ineligible for the remaining months of TMA if it:

1. Fails without good cause (see 468 NAC 4-001.01A2d(6)) to submit required reports of earnings and child care costs;
2. No longer includes a dependent child; or
3. Has gross monthly earnings (less child care costs) during the preceding three-month period in excess of 185 percent of the FPL.

If the unit regains grant eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant eligibility because of earnings, the original TMA cycle resumes. If the unit receives three or more ADC grants, then again loses grant eligibility because of earnings, a new TMA cycle begins.

{Effective 5/8/05}

4-001.01A2d(2) Report Requirement: The unit must provide a report of gross monthly earnings and child care costs as billed or paid for each three-month period of months 7 through 12.

Note: The unit is not required to report unearned income.

{Effective 10/15/2002}

4-001.01A2d(3) Change in Unit: If a unit member leaves, the worker must redetermine income eligibility for the remaining unit members.

If a responsible relative returns to the home, the unit size is increased and the responsible relative's income is budgeted to the TMA unit.

4-001.01A2d(4) Income Eligibility: The worker averages the unit's earned income for the three-month report period to determine income eligibility. If the unit has earned income (minus the cost of child care) equal to or less than 185 percent of the Federal Poverty Level, they are eligible for TMA.

4-001.01A2d(5) Good Cause for Terminating Employment: Some examples of good cause for terminating employment include:

1. Illness of the employed unit member;
2. Illness of another unit member requiring the presence of the employed member;
3. Unavailability of transportation (including public transportation);
4. Work demands or conditions that make continued employment unreasonable, such as working without being paid on schedule;
5. Acceptance of employment that requires the unit member to leave other employment;
6. Acceptance of a bona fide job offer which, because of circumstances beyond the control of the unit member, subsequently does not materialize; or
7. Leaving a job in connection with patterns of employment in which workers frequently move from one employer to another, such as in migrant farm labor or construction work.

4-001.01A2d(6) Good Cause for Failing to Submit a Quarterly Report Form (QRF): The following are some examples of good cause for failing to submit a QRF:

1. Death of the parent or caretaker relative;
2. Hospitalization of a unit member during the due period for the QRF (the client is responsible for providing verification of hospitalization);
3. Natural disaster (the Central Office will issue instructions when these situations occur);

4-001.01A2e After Month 12: When a client has exhausted his/her months of TMA, s/he may still be eligible for ADC/MA or another medical assistance program.

{Effective 10/15/2002}

4-001.01B Individuals Ineligible for Assistance Grant But Eligible for MA: Eligibility for the following individuals is determined using eligibility requirements listed in 468 NAC 4-001.01. The worker must assess eligibility for these individuals.

1. Individuals who have resources in excess of resource limits for an ADC grant;
2. Individuals who have income in excess of budgetary standards for an ADC grant;
3. Essential children, as defined by SSI, or medical assistance only recipients;
4. Children sanctioned for failure or refusal to cooperate with Employment First;
5. Unborns beginning with the date of the pregnancy verification (the date of request or the date that the pregnancy is known to the agency), through the end of the second trimester; and
6. An individual who is ineligible for a grant because of a drug related felony committed after August 22, 1996.

{Effective 10/10/2007}

4-001.01B1 (Reserved)

4-001.01B2 Medical Assistance for Aliens:

4-001.01B2a Restricted Medical Assistance: An alien who meets ADC eligibility requirements (see 468 NAC 2-000) may receive medical assistance if s/he has the sudden onset of an emergency medical condition (see 468 NAC 4-001.01B2a(1)) and is not lawfully admitted for permanent residence in the United States.

Note: For an alien who is aged, blind, or disabled, see 469 NAC 4-001.02A. If an alien age 18 or younger does not meet the deprivation requirement, see Title 477.

{Effective 5/8/05}

4-001.01B2a(1) Emergency Medical Condition: An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to the patient's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

The State Review Team (SRT) makes the determination that the client has an emergency medical condition.

4-001.01C Cooperation in Obtaining Health Insurance: As a condition for eligibility for MA, a client is required to enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations. A client who refuses to enroll or remain enrolled is removed from the MA unit but the ADC child(ren) remains eligible.

4-001.01D Presumptive Eligibility for Unborn: A pregnant woman may apply at a qualified provider's office (see 471 NAC 28-001.01) for ambulatory prenatal services. The provider makes a presumptive determination of the woman's eligibility based on income only. Income of the woman and the child's father (if he is in the home) is considered. The provider does not investigate resources or other eligibility requirements.

The provider must notify the local office within five working days after the determination of presumptive eligibility.

The woman's presumptive eligibility continues through the day on which the local office makes a determination on the woman's continued eligibility.

The worker must send a Notice of Action notifying the woman of the determination of her continued medical assistance. The worker also sends a copy of the Notice of Action to the provider.

{Effective 12/02/2006}

4-001.01E Guidelines for Parental Responsibility: The worker must use the following guidelines to determine if a child is considered part of the household:

1. If the child is living in the same household with parent(s), the parent(s)' income must be included.
   Exceptions: Home and Community Based and MR Waiver: If a child, living in the parent(s)' home is receiving Medicaid services through a Home and Community Based Service waiver or an MR waiver, the parent(s)' income and resources are not deemed. This does not require Central Office review.

   Katie Beckett: If the child is not receiving waiver services, the income and resources of a parent are not deemed if the minor is severely disabled, AABD-eligible, and would require the level of care provided in a medical institution (Katie Beckett child) and requires certain medical services for special needs (see 471 NAC 12-014). This exception applies only if the cost of care in the home is less expensive than the cost of care in a medical institution.

2. If the child is temporarily absent from the home (generally 90 days or less) but is still considered part of the household, the parent(s)' income must be included. Temporary absence includes, but is not limited to, school attendance where the child returns to the home on a regular basis (weekends, vacations, or summers). Residence in an institution for mental retardation or mental illness for 90 days or less may be considered temporary absence if the child was living in the parent(s)' household before institutionalization and will return to the parent(s)' household upon discharge.
3. If the child is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be included.

If income is deemed from a parent to a child in an IMD, see 477 NAC 2-007.04.

4-001.01F Requirements for Two-Parent Families: Two-parent families must meet the following eligibility requirements.

4-001.01F1 Hundred-Hour Rule: Neither medically needy parent can be working more than 100 hours in a calendar month. The case manager will consider if the parent(s) worked more than 100 hours in any of the three previous calendar months, or if the parent(s) is scheduled to work more than 100 hours for the month of application.

Work study is considered employment when determining the 100 hours.

4-001.01F2 Physical or Mental Incapacity of a Parent: A needy child is considered deprived of parental support or care if either parent has a physical or mental incapacity. If the incapacitated parent is an ineligible alien, s/he is not eligible to be included in the medical unit. However, the children - who must be citizens or lawfully admitted aliens - and the spouse of the incapacitated ineligible alien, if otherwise eligible, may receive assistance. If a citizen or legal alien who qualifies as an incapacitated parent is married to an ineligible alien, the ineligible alien is ineligible, but the rest of the unit may be eligible.

The incapacitated parent does not have to be included in the unit if s/he is receiving AABD/MA and is considered disabled or blind. An incapacitated parent who is receiving SDP/MA must be included in the ADC unit (see 468 NAC 3-006). If the parent is receiving Aid to the Aged, s/he must be determined incapacitated according to 468 NAC 4-001.01F2a.

4-001.01F2a Definition of Physical or Mental Incapacity: "Physical or mental incapacity" means any physical or mental illness, impairment, or defect which is so severe as to substantially reduce or eliminate the parent's ability to provide support or care for a child(ren). The incapacity must be expected to last at least 30 days.

Note: Age itself is not considered incapacity.

4-001.01F2b Determination of Incapacity: If a parent is receiving RSDI, SSI, AABD, or SDP based on disability or blindness, s/he qualifies as incapacitated. For all others the determination of incapacity is made by the State Review Team (SRT). For eligibility of the parent for AABD/MA or SDP/MA, see Title 469.

4-001.01F2b(1) Release to Work: If the client is released by the doctor to return to work before the review set by the State Review Team, the client is determined no longer incapacitated if s/he returns to work.

4-001.01F2b(2) Requirement to Cooperate: The incapacitated parent is required to cooperate in obtaining treatment or rehabilitative or vocational services that are recommended on Form DM-5R. If the incapacitated parent fails to obtain the treatment or services, the case is ineligible.

4-001.01G Medical Assistance and Employment First Limits: Medical assistance is not time limited for individuals who refuse a grant or those who are ineligible for a grant because of the $10 payment minimum (see 468 NAC 3-003).

4-001.01H Six Months' Continuous Eligibility: Children from birth through age 18 are eligible for 6 months of continuous Medicaid from the date of initial eligibility unless:

1. The child turns 19 within the 6 months;
2. The child moves out of state;
3. The worker determines that the original eligibility was based on erroneous or incomplete information;
4. The child dies; or
5. The child enters an ineligible living arrangement (see 477 NAC 2-008.01).

No income or resource review is required.

For budgeting after the six month's continuous Medicaid, see 477 NAC 1-010.01.

4-002 Assignment of Third Party Medical Payments: Application for medical assistance constitutes an automatic assignment to the Nebraska Department of Health and Human Services of the client's rights to third party medical payments. For child support requirements, see 468 NAC 2-019 ff. This assignment includes the rights of the client as well as the rights of any other member of the ADC/MA unit.

This assignment gives the Department the right to pursue and receive payments from any third party liable to pay for the cost of medical care and services of the client or any other unit member and which otherwise would be covered by NMAP.

4-002.01 (Reserved)

4-002.02 Third Party Payments Not Assigned: The following third party payments are not subject to the automatic assignment provision:

1. Medicare benefits; and
2. Payments from income-producing policies which subsidize the client's income while s/he is hospitalized or receiving medical care, regardless of the type of medical service being provided.

4-002.03 Cooperation in Obtaining Third Party Payments: As a condition of eligibility for medical assistance, the client must cooperate in obtaining third party payments unless s/he has good cause for noncooperation (see 468 NAC 4-002.03B3 ff.). Cooperation includes any or all of the following:

1. Providing complete information regarding the extent of third party coverage which s/he or any other unit member has or may have. This includes coverage provided by a person not in the unit or by an agency;
2. Providing any additional information or signing claim forms which may be necessary for identification and collection of potential third party payments;
3. Appearing as a witness in a court or another proceeding, if necessary;
4. Notifying the Department of any action s/he is initiating to recover money from a liable third party for medical care or services. This includes the identity of the third party as well as the entire amount of any settlement, court award, or judgment;
5. Reimbursing the Department or paying to the provider any payments received directly from a third party for any services payable by NMAP; and
6. Taking any other reasonable steps to secure medical support payments.

4-002.03A Refusal to Cooperate: The worker is responsible for determining noncooperation by the client. This determination is based on the client's failure or refusal to fulfill the requirements listed in 468 NAC 4-002.03.

4-002.03B Opportunity to Claim Good Cause

4-002.03B1 Notification of Right: The worker must notify the client of the right to claim good cause for noncooperation at the intake interview, redetermination, and whenever cooperation becomes an issue.

The worker must give the client a verbal explanation of good cause and the opportunity to ask questions.

At the initial interview the client must sign a written explanation of good cause, Form IM-60.

4-002.03B2 Worker's Responsibilities If Good Cause Claimed: If the client claims good cause, the worker must:

1. Explain that the client has the burden of establishing the existence of a good cause circumstance; and
2. Obtain a signed statement from the client listing the reason(s) for claiming good cause. The client is allowed 20 days to present evidence of the claim.

4-002.03B3 Acceptable Circumstances for Good Cause: Good cause claims must be substantiated by signed statements. When documentary evidence is not available the client shall furnish sufficient information as to the location of the information.

To establish good cause, the evidence must show that cooperation would not be in the best interest of the client or another unit member for whom assignment is sought. Good cause includes the following circumstances, provided proper evidence is obtained.

4-002.03B3a Physical or Emotional Harm to the Client or Other Unit Member: Good cause exists if the client's cooperation in assigning benefits is reasonably anticipated to result in physical or emotional harm to the client or another unit member. Emotional harm must only be based upon a demonstration of an emotional impairment that substantially reduces the individual's functioning.

4-002.03B3a(1) Documentary Evidence: Documentary evidence which indicates these circumstances includes:

1. Medical records which document emotional health history and present emotional health status of the client or other unit member;
2. Written statements from a mental health professional indicating the diagnosis or prognosis concerning the emotional health of the client or other unit member;
3. Court, medical, criminal, protective services, social services, psychological, or law enforcement records which indicate that the third party might inflict serious physical or emotional harm on the child or parent/needy caretaker relative; or
4. Signed statements from individuals other than the client with knowledge of the circumstances which provide the basis for the claim.

4-002.03B3a(2) Evidence Not Submitted by Client: When the claim is based on the client's anticipation of physical harm and corroborative evidence is not submitted in support of the claim the worker must:

1. Investigate the good cause claim when s/he believes that the claim is credible without corroborative evidence and corroborative evidence is not available; and
2. Find good cause if the client's statement and the investigation indicate that the client has good cause for refusing to cooperate.

4-002.03B3a(3) Worker Considerations: If the determination of good cause is not substantiated by documentary evidence, the worker must consider and document the following evidence:

1. The present physical or mental state of the client;
2. The physical or mental health history of the client;
3. Intensity and probable duration of the physical or mental upset; and
4. The degree of cooperation required by the client.

4-002.03B4 Decision on Good Cause: The worker must determine good cause and notify the client of the decision on a Notice of Action. If the worker determines that good cause does not exist, s/he allows the client ten days to respond from the date that the Notice of Action was mailed. If the client does not cooperate, withdraw the application, or request the case closed, a sanction is imposed (see 468 NAC 4-002.03C).

4-002.03B5 Delay of Assistance Pending Determination: The agency must not deny, delay, or discontinue assistance pending a determination of good cause if the client has complied with the requirements of providing acceptable evidence or other necessary information. In most instances, a good cause determination must be made within 30 days following the receipt of a claim.

4-002.03B6 Review of Good Cause: At the time of each redetermination, the worker must review a good cause claim based on a circumstance that is subject to change.

If circumstances remain the same, no action is required. A new determination is necessary if circumstances have changed. If good cause no longer exists, the requirement to cooperate must be enforced.

4-002.03C Sanction for Refusal to Cooperate: If the client fails or refuses to cooperate and there is no good cause claim or determination, the appropriate sanction is applied.

If the reason for noncooperation is the client's failure or refusal to provide information about or obtain third party medical payments (see 468 NAC 4-002.03), the client is ineligible for grant and MA. Eligibility of the dependent child(ren) is not affected. Ineligibility continues for the client until s/he cooperates or cooperation is no longer an issue.

4-002.04 Third Party Payments Received Directly: If the client receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by NMAP, the worker must take the following actions:

1. Send a demand letter advising the client that s/he must reimburse the Department or the provider. The client is allowed ten days from the date of notification to reimburse the medical payment. For an applicant, the worker must not delay determination of eligibility for assistance and authorization for payment pending the applicant's reimbursement. At the time the application is approved, the worker must notify the client of the number of days left in which to reimburse the payment;
2. If the client refunds within ten days, take no further action; or
3. If the client fails or refuses to refund within ten days, consider the entire third party payment as unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

If the insurance payment exceeds NMAP rates, the excess is considered unearned income unless paid out on other medical services or supplies.

Regardless of the existence of a good cause claim, any third party medical payment that is received directly by the client must be reimbursed.

4-002.05 Willfully Withheld Information: When the evidence clearly establishes that a client willfully withheld information regarding a third party medical payment which resulted in an overpayment of NMAP expenditures, the worker must refer the case to the Special Investigation Unit, Central Office, or in the Omaha Office to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker must take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker must complete normal case actions which include applying the appropriate sanction in this section.

4-002.06 Termination of Assignment: When a client's grant and medical case is rejected or closed, or an individual is removed from the medical unit, the assignment provision is terminated. The client's rights to any future third party and medical support payments are automatically restored effective with the date of ineligibility. However, the assignment remains in effect for the time period during which the client was on medical assistance.

4-002.07 Child Support Enforcement Services: Child Support Enforcement Services are provided to an ADC/MA child age 18 or younger. Unless the custodian has good cause (see 468 NAC 4-002.03B), s/he is required to cooperate with the Child Support Enforcement Unit in obtaining support. If the custodian fails or refuses to cooperate with CSE, the ADC child continues to be eligible.

{Effective 5/8/05}

4-003 Age Requirement for a Dependent Child: A dependent child is eligible through the month of his/her 18th birthday. A child is eligible through the entire month of his/her 19th birthday if s/he is a full-time student regularly attending a secondary school, or the equivalent level of vocational or technical training (this does not include college).

An 18-year-old is eligible through the month of graduation from high school or the equivalent level of vocational or technical training.

For medical eligibility for a child age 18 or younger who no longer meets the definition of a dependent child, see Title 477.

{Effective 8/18/03}

4-004 Effective Date of Medical Eligibility: The effective date of eligibility for MA is determined according to provisions in the following regulations. If an individual is eligible one day of the month, s/he is eligible the entire month.

4-004.01 Prospective Eligibility: Prospective eligibility is effective the first day of the month of request if the client was eligible for NMAP in that same month and had a medical need.

4-004.02Retroactive Eligibility: Retroactive eligibility is effective no earlier than the first day of the third month before the month of request if the following conditions are met:

1. Eligibility is determined and a budget computed separately for each of the three months;
2. A medical need exists; and
3. Elements of eligibility were met at some time during each month.

An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

If a client at the time of application declares that s/he incurred medical expenses during the retroactive period and eligibility is not approved, the case record must contain documentation of the reason the client was not eligible in one or more months of the retroactive period.

4-004.02A Medical Effective Date of a Parent and an Unborn: The medical effective date for an eligible parent and an unborn child can be determined up to three months before the request for Medicaid, as long as the pregnancy is medically verified to have existed at the beginning of this retroactive period.

If the physician or licensed medical professional verifies that the woman was pregnant during one or more of the three months before the month of request, application for retroactive Medicaid eligibility may be approved for the month(s) in which all other criteria were met and medical expenses were incurred. The worker shall determine eligibility for each month individually.

See 468 NAC 2-004.02 for the requirement for an SSN for a newborn.

{Effective 5/8/05}

4-004.03 Parent Not in the Unit: When the parent is not in the unit, e.g., an ineligible or sanctioned parent who is out of the unit, retroactive eligibility may be determined for the eligible dependent child(ren) if a medical need exists.

If the income of a parent (eligible or ineligible) is considered in determining MA for the dependent child, then the medical obligations and/or expenses of that parent must be considered to meet the share of cost of the unit. If income of a minor's parent(s) is considered in determining MA for the minor parent and his/her child(ren), the worker must consider the medical obligations and/or expenses of the minor's parent(s) and any other dependents of the parent(s) who are in the home and who are or could be claimed by the parent(s) as dependents for income tax purposes.

4-005 (Reserved):

4-006 Resources

4-006.01 Maximum Resource Levels: The established maximums for available resources which the client may own and still be eligible for MA only are as follows:

One member unit	$4,000
Two member unit or family	6,000
Three member unit or family	6,025
Four member unit or family	6,050
Each additional individual	+ 25

4-006.02 (Reserved)

4-006.03 Treatment of Resources: For the treatment of all resources except those in the following regulations, the criteria outlined in 468 NAC 2-008 ff. are used.

4-006.03A Motor Vehicles: The worker must disregard one motor vehicle regardless of its value as long as it is necessary for the client or a member of his/her household for employment or medical treatment. If the client has more than one motor vehicle, the worker must exclude the vehicle with the greatest equity. Any other motor vehicles are treated as non-liquid resources and the equity is counted in the resource limit. The client's verbal statement that the motor vehicle is used for employment or medical treatment is sufficient.

4-006.03B Essential Property: If the client owns a resource that is used in his/her trade or business, the resource is disregarded, regardless of the value. This includes real property such as land, houses, or buildings as well as personal property such as farm machinery, business equipment, livestock, poultry, crops, tools, safety equipment, or business bank accounts as long as the funds are separated from other liquid resources. The client or a responsible relative must be actively involved in the trade or business. See 468-000-330 for examples.

4-006.03B1 Nonbusiness Property: A maximum of $6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities is excluded from resources. For instance, an individual may maintain livestock for consumption in his/her own household. There is no limit on the value of livestock, poultry, and crops for the household's own consumption (see 468 NAC 2-008.02B).

The property must be in current use or there is the reasonable expectation that use will resume.

Any equity in excess of $6,000 is counted as a resource. If the excess resource is real property, see 468 NAC 2-008.07B5 for regulations on liquidating real property.

4-006.03C Funds Set Aside for Burial: See 469 NAC 2-009.07A3.

4-006.04 Reduction of Resources: An application for an individual who has excess resources may be held pending until the resources are reduced. Excess resources may be reduced by paying obligations for medical costs. Medical eligibility begins with the first day of the month of the incurred obligation which was used to reduce the resources to the allowable maximum (see 468 NAC 4-006.01). Medical eligibility may not be established earlier than the three-month retroactive period.

4-006.05 Individual Added to an Existing Unit: The resources of the total unit (the previous unit plus the added individual) are compared to the resource maximums (see 468 NAC 4-006.01) based on the total unit size.

{Effective 12/02/2006}

4-006.06 Deprivation of Resources for Medical Assistance: See 469 NAC 2-009.10Bff.

{Effective 12/02/2006}

4-007 Treatment of Income: For the treatment of income in NMAP, the criteria outlined in 468 NAC 2-009 ff. are used, with the exceptions in the following regulations. For consideration of income deemed to a minor parent, see 468 NAC 2-007.02B1. For earned income, see 468 NAC 2-009.02; for unearned income, see 468 NAC 2-009.04.

4-007.01 Medical Insurance Disregards: The cost of medical insurance premiums is deducted if a member of the unit (or a grandparent whose income is deemed to a minor parent) is responsible for payment. The Medicare Part B premium which the client is responsible for paying is included in this disregard.

Exception: The cost of premiums for income-producing policies is not allowed as a medical deduction on a medical budget.

4-007.02 Earned Income Disregards

4-007.02A One Hundred Dollar Disregard: A $100 disregard is applied to gross earned income of each employed individual.

{Effective 10/15/2002}

4-007.02B Child Care Disregard: If a client requires child care, s/he is allowed the actual cost of child care as billed or as paid for the month.

When a client goes to MA only or MA with a Share of Cost, the client is no longer eligible for Child Care Subsidy as Current Family. If the child care expense makes the client eligible for medical, the worker budgets the actual child care expense (including what is paid by Child Care Assistance, if any).

4-007.02C Parent in the Home But Not the Unit: When the parent is in the home but not in the unit, his/her income is counted toward the unit. The parent's gross earned income minus the $100 earned income disregard and child care disregard, if appropriate, is counted.

Unearned income is counted in full toward the unit.

{Effective 10/15/2002}

4-009 Prospective Budgeting: The N-FOCUS System averages the income used on the Medicaid budget based on what data the worker has entered. If the household income fluctuates (i.e., paid hourly and hours/pay period vary), the worker must enter income from the three most recent consecutive months. If the income is stable (i.e., client receives the same amount of pay each pay period), one month's income is used. Weekly or bi-weekly earnings are converted by N-FOCUS. This converted monthly amount is used to project eligibility for the next three months unless:

1. A significant change occurs within the next three months and is reported by the client; or
2. The worker can anticipate a significant change, such as a benefit ending.

{Effective 5/8/05}

4-009.01 Change: The client must report the following changes:

1. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle.
2. Change in unit composition, such as the addition or loss of a unit member;
3. Changes in residence;
4. New employment;
5. Termination of employment;
6. Changes in the amount of monthly income, including:
   a. All changes in unearned income; and
   b. Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes, 30 hours per week is considered full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change; and
7. Change in health insurance premium.

4-009.01A General Rules: For procedures used in handling changes in income, see 468 NAC 2-015.02A.

{Effective 5/8/05}

4-009.01B Procedures for Changes: The worker must first determine if the change(s) affects MA eligibility. If it does, the system:

1. Compares resources to the resource limit; (see 468 NAC 4-006.01);
2. Compares the income to the appropriate income level (see 477 NAC 4-001.02 ff.);
3. Determines eligibility based on the household composition;
4. Recomputes the budget; and
5. Generates an adequate and/or timely Notice of Action (see 468 NAC 1-009.03Aff.).

4-009.01C Lump Sum Treatment for ADC/MA: If the client is receiving medical only when a lump sum is received, the lump sum is not considered income. Any unspent remainder is considered a resource in the month following the month of receipt or report taking into account timely notice provision.

Exception: The unspent portion of an RSDI or SSI retroactive payment is excluded for six months following the month of receipt.

{Effective 5/8/05}

4-010 Medically Needy Income Level (MNIL): The medically needy income level is determined by the number of family members. Ineligible or sanctioned parents, or children who the parent chooses not to include in the unit are included in the MNIL for those family members who are subject to the MNIL. If the parent chooses to exclude a child, any income of the child is also excluded from the Medicaid budgeting process. Children eligible under other Medicaid categories, such as Poverty Level Children's Medicaid or Kids Connection, are still considered when setting the family size for purposes of establishing the appropriate MNIL.

If income of a minor's parent(s) is considered in determining Medicaid eligibility for a minor parent and child(ren), the minor's parent(s) and any other dependents of the parent(s) who are in the home and who are or could be claimed by the parent(s) as dependents for income tax purposes are counted in setting the medically needy income level.

In determining the MNIL, the following individuals are considered:

1. Client;
2. Spouse; and
3. Minor child(ren) (including unborns).
   Note: When it is medically verified that there is more than one fetus, all unborns are considered in the MNIL.

The parent may decide what family members will be included as participants in the Medicaid unit.

The countable income is compared to the appropriate MNIL to determine if those family members who are subject to the MNIL are eligible or are subject to a Share of Cost.

For examples of Medicaid budgeting, see 468-000-303.

{Effective 5/8/05}

4-010.01 Medical Budget Periods: The medical budget is normally computed on a monthly basis. See 468-000-313 for procedures.

{Effective 5/8/05}

4-011 Required Copayments: Effective April 1, 1994, ADC adults are required to pay a copayment for the medical services listed at 468-000-205. Copayment amounts are also listed at 468-000-205.

4-011.01 Covered Persons: With the exceptions listed at 468 NAC 4-011.02, ADC adults are subject to the copayment requirement.

The client's Medicaid card will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES).

4-011.02 Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as assisted living facilities, and adult family homes;
5. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Model Waiver for Children with Mental Retardation and Their Families; or the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities; and
6. Individuals with SOC (both before and after the obligation is met);
7. Individuals who receive assistance under SDP (program 07); and
8. Individuals who are enrolled in Health Maintenance Organizations.

{Effective 5/8/05}

4-011.03 Covered Services: For covered and excluded services, see 468-000-205.

4-011.04 (Reserved)

4-011.05 Client Rights: If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

If the client is unable to pay the required copayment, s/he may inform the provider of the inability to pay. While the provider must not refuse to provide services to the client in this situation, the client is still liable for the copayment and the provider may attempt to collect it from the client.

The client has the right to appeal under 465 NAC 2-001.02.

4-012 Nebraska Health Connection (NHC): Managed care is required for all active Medicaid-eligible individuals except those excluded groups listed at 468-000-347. For more information, see Title 482.